STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. 19,972
	)	
Appeal of	)	

INTRODUCTION

The petitioner appeals decisions by the Department of Aging and Independent Living (DAIL) (1) substantiating a report of neglect by the petitioner involving a vulnerable adult who was a resident in a Level III residential care home operated by the petitioner and (2) finding licensing regulation violations at the residential care home.

The petitioner first requested a fair hearing challenging the substantiation of neglect on October 4, 2005. Petitioner then requested a fair hearing challenging DAIL's determination of licensing violations. The issues were joined.

A fair hearing was first convened by Hearing Officer Daniel Jerman on March 21, 2006. Partial testimony was taken that day.

Petitioner filed motions to resume the hearing and to disqualify the hearing officer on May 1, 2006. At a status conference held on May 18, 2006, Hearing Officer Jerman denied the motion to disqualify and granted the motion to

resume the hearing. The hearing was scheduled for July 6, 2006.

Petitioner requested a copy of the hearing tape from March 21, 2006. Due to an equipment malfunction, the hearing tape was not available and the parties were so notified.

On June 20, 2006, the parties were notified that the hearing would be continued to August 2 and 3, 2006 before a new hearing officer.

The hearing reconvened August 2, 2006 before Hearing Officer Lila Shapero. Testimony was taken on August 2 and 3, and September 7. At the close of September 7's testimony, the State indicated their intention to file criminal charges against the petitioner. The hearing was continued to September 19, 2006, but petitioner filed a motion to continue the hearing on September 18, 2006. The hearing was continued to October 17, 2006 when testimony was completed.[1] Petitioner's motion to continue the fair hearing pending resolution of criminal charges filed by the State was denied.

On October 23, 2006, petitioner filed a separate request for fair hearing asking that the May 2005 decision by DAIL to

[1] The recording equipment malfunctioned on August 2, 2006. But, the petitioner employed a court reporter for the reconvened hearing. There is a transcript from the court reporter for said date.

limit the number of residents be lifted. The issue was incorporated into this case.

Briefing was completed by February 1, 2007. The decision is based upon the evidence adduced at hearing.

FINDINGS OF FACT

1. The petitioner is the owner and manager of a Level III residential care home (MVH) in Concord, Vermont. Petitioner has operated MVH for over twelve years.

2. A Level III residential care home provides general supervision for its residents' physical and mental well-being including nursing overview and medication management. Although the residents at MVH are a range of ages, the majority are younger individuals with psychological diagnoses.

3. This case was triggered by the petitioner making a report to DAIL on April 18, 2005 that a resident, R.R., had died at MVH on April 9, 2005. DAIL opened an investigation to review what occurred and whether MVH was in compliance with licensing regulations.

4. At the time of his death, R.R. was a twenty-two-year-old male diagnosed with schizophrenia, ADHD, and oppositional defiance disorder. R.R. received psychiatric

care from Dr. K-L at Northeast Kingdom Health Services (NEKHS). His medications included Lorazepam, Colace, and Clozapine (clozaril). R.R. received medical care through the Concord Health Center.

5. During April 2005, the petitioner employed L.D., registered nurse, T.S., care attendant, and S.J., care attendant. As manager, the petitioner was required to be onsite thirty-two hours per week.

6. L.D. worked at MVH from March 2002 until November 2005. L.D. had worked as a registered nurse for forty-four years primarily in long-term care institutions. L.D. worked under contract. Her contract did not specify hours or a work schedule. L.D. normally worked in the evenings. L.D. was on call. L.D.'s responsibilities included patient assessments and care plans, overseeing medications, and training staff. Level III residential care homes are not required to have a nurse at the facility full-time. To ensure that residents receive their medications, nursing staff can delegate these duties to care attendants once the nursing staff trains care attendants to administer medication.

7. The care attendants spelled each other at MVH. Each care attendant worked a shift spanning several days and

slept at MVH when on duty. The care attendants were not LPNs. They were taught by L.D. to administer medication.

8. R.R. spent most weekends with his mother, C.R., and younger brother. R.R. visited his mother the weekend of April 2, 2005. C.R. noted that R.R. had a fever.

9. Based on the testimony of C.R., T.S., petitioner, N.T., DAIL nurse surveyor, and documentary evidence, the following chart reconstructs information setting out R.R.'s temperature from April 2 to April 9, 2005.

Date	Time	Temperature
Sat, April 2		102
Sun, April 3	7:00 a.m.	105
	1:00 p.m.	100
	4:00 p.m.	102.6
Mon, April 4	6:30 a.m.	104
	11:00 a.m.	100.2
Tue, April 5		
Wed, April 6	11:00 a.m.	99
Thu, April 7	8-8:30 a.m.	106
	10:30 a.m.	96.3
	11:30 a.m.	97.8
	8:00 p.m.	98.7
Fri, April 8	9:00 a.m.	100
	12:30 p.m.	98.7
	3:00 p.m.	100
	7:45 p.m.	98.7
Sat, April 9	8:15 a.m.	103

10. C.R. testified that over the April 2 weekend, R.R. had fever and chills and stayed in bed for most of the weekend. C.R. returned R.R. to MVH Sunday evening. She telephoned MVH on Monday to report that R.R. had a fever that weekend and to check with MVH about his health. C.R. was told his temperature readings. S.J. was the care attendant that day.[2] S.J. made one entry in R.R.'s Progress Notes on April 6, 2005 that she took his temperature and gave him one PRN (Tylenol) with his evening medications.

11. Every resident at MVH has Physician Standing Orders. In R.R.'s case, the Physician Standing Orders allow one dose of Acetaminophen (Tylenol) 325mg every twelve hours as needed. Dr. K-L made the standing order for Tylenol.

12. C.R. stopped at MVH on Wednesday and thought R.R. looked fine. She was told his temperature was 99. That same day, petitioner learned that R.R. had a fever during the prior weekend.

13. T.S. was the caregiver Thursday, April 7 until Saturday morning, April 9.

14. T.S. testified that R.R. told her that he had a temperature of 106 when he was at his mother's home over the

[2] S.J.s' testimony from March 21, 2006 is lost. Petitioner's efforts to find S.J. for the rescheduled hearing were unsuccessful. The parties were unable to stipulate to her earlier testimony.

weekend. C.R. telephoned MVH and informed T.S. about R.R.'s health problems the prior weekend. T.S. took R.R.'s temperature while he was still in bed and found that it was 106. T.S. noted that R.R. slept fully clothed with a tee shirt, hooded sweatshirt, heavy jeans, socks, and used two comforters. C.R. and petitioner corroborated that R.R. normally slept fully clothed with two comforters. T.S. informed the petitioner that R.R. had a 106 temperature that morning. T.S. also informed C.R. of the 106 temperature during their telephone call. After their call, C.R. telephoned Concord Health Center for an appointment. The Health Center did not have an appointment until 4:00 p.m. and she was told to bring R.R. to the ER. C.R. testified that she called T.S. back and had T.S. ask R.R. if he would go to the ER which he refused.

15. T.S. did not contact L.D. or Dr. K-L about R.R.'s high temperature. T.S. testified that she did not know the identity of R.R.'s medical doctor. Petitioner did not contact L.D., R.R.'s medical doctor, or Dr. K-L about R.R.'s high temperature after T.S. informed her of R.R.'s high temperature. Neither reported to R.R.'s medical providers that R.R. refused to go to the ER.

16. T.S. administered two extra-strength Tylenol to R.R. on Thursday at 9:30 a.m. and at 1:30 p.m. R.R.'s temperature was in the normal range the remainder of Thursday. In all, T.S. administered 2000mg or more than six times the dose allowed under the standing orders. After R.R.'s death, petitioner and T.S. completed a medication incident report.

17. T.S. testified that R.R. appeared fine on Thursday. He went to the mall twice with another resident and told T.S. that he felt fine.

18. On Friday, R.R. slept in. T.S. took his temperature at 9:00 a.m. According to T.S., R.R. said he was fine but felt tired. After lunch, T.S. looked in at R.R. and found that R.R. had messed his pants and bed. R.R. had never had an episode of stool incontinence during his three and a half years at MVH. T.S. asked R.R. if wanted to go to the ER and he refused. T.S. did not call L.D. or Dr. K-L and did not report to R.R.'s medical providers that he refused to go to the ER. C.R. called T.S. that day and was told that R.R. had diarrhea. C.R. testified that she was not told that R.R. had stool incontinence. C.R. requested T.S. to ask R.R. to go to the ER. T.S. once again asked R.R. but he refused to go to the ER. T.S. did not follow up with L.D. or any of

R.R.'s medical providers. T.S. administered one extra-strength Tylenol (500mg) at 1:30 p.m. R.R. stayed in his room most of the day.

19. On Friday afternoon, T.S. reported to petitioner that R.R. had stool incontinence. Petitioner told T.S. to find out if R.R. would go to the ER, and if R.R. refused to go to the ER, T.S. should keep an eye on him. R.R. refused to go to the ER. T.S. did not contact L.D. or Dr. K-L or let any of R.R.'s medical providers know that R.R. had an episode of stool incontinence. Petitioner did not contact L.D., R.R.'s medical doctor, or Dr. K-L or let any of R.R.'s medical providers know that he refused to go to the ER.

20. On Saturday morning, T.S. took R.R.'s temperature at 8:15 a.m. R.R. had a temperature of 103. T.S. was leaving her shift and informed S.J. about R.R.'s temperature. R.R. stayed in his room. When S.J. checked on R.R. at 1:00 p.m., she found that he had died.

21. Dr. C. is now a private medical examiner. During 2005, he worked for the Vermont Medical Examiner's Office and investigated the death of R.R. He concluded that the cause of death was (1) lobar pneumonia and (2) acute Clozapine intoxication. The manner of death was accident (excess medication). According to Dr. C., serious respiratory

infections can decrease the enzymes that metabolize drugs such as Clozapine. When Clozapine is not properly metabolized, Clozapine levels can rise to toxic levels. According to Dr. C., medical staff need experience dealing with pulmonary infections. It has been his experience that patients diagnosed with pneumonia may appear to be improving and then suddenly die. Caretakers would not have the expertise to evaluate pulmonary infections.

22. Dr. C. was questioned about Clozapine side effects and warnings. The manufacturer's warning indicates that fever and flu-like symptoms should be medically evaluated.

23. Petitioner and T.S. testified they were unaware of the side effects and warning signs for Clozapine. L.D. testified that she was aware of Clozapine's side effects. According to L.D., they had the printouts on medications.

24. Dr. C. testified that a 106 temperature on its own (patient is not taking Clozapine) is very serious and requires medical attention. Dr. C. was questioned about patients who refuse care and responded that he would strongly communicate with the patient about the risks and try to persuade the patient to seek care.

25. Dr. K-L presently works for the Sleep Disorders Clinic at Dartmouth Hitchcock Medical Center. Prior to her

employment at Dartmouth Hitchcock, Dr. K-L was a staff psychiatrist at NEKHS. She testified that she was responsible for treatment and psychiatric medication management of patients and mental status evaluations. She is board certified in psychiatry.

26. Dr. K-L testified that NEKHS treated ten or eleven patients from MVH and she followed five or six of the patients. She was R.R.'s treating psychiatrist for two to three years. Dr. K-L described R.R. as a young man with a long history of psychological issues including hospitalizations during his teens. At the outset of her treatment, R.R. presented as very paranoid, being afraid to be in public, and being afraid of choking.

27. Dr. K-L determined that R.R. needed a change in medication and discussed Clozapine with R.R. and C.R. C.R. was very involved in R.R.'s care and came with him to appointments. Dr. K-L testified that Clozapine is not a first line choice because bi-weekly blood work is needed and it's expensive, but R.R.'s medications were not successfully controlling his symptoms. According to Dr. K-L, all anti-psychotic medications have side effects. Dr. K-L testified that she explained risks and benefits to R.R. and C.R. but she did not specifically recall whether she mentioned fever

or flu-like symptoms. C.R. testified that she remembered an explanation of benefits but did not remember a discussion of risks. Dr. K-L testified that she normally gives patients a hand-out describing Clozapine.

28. Dr. K-L testified that R.R. improved after he began Clozapine. He was less afraid, able to ride in cars and his fears about choking had improved.

29. Dr. K-L testified that when she began at NEKHS, MVH already had a number of residents who were prescribed Clozapine. According to Dr. K-L, MVH had more residents prescribed Clozapine than the other residential care home in the area.

30. Dr. K-L testified that she had prescribed Tylenol PRN (as needed basis). Dr. K-L stated she was uncomfortable writing physician standing orders because she wanted the staff to distinguish between medical and psychological issues. She was only providing psychiatric care for R.R. Her standing order for Tylenol was 325mg every twelve hours. She testified that Tylenol presented two issues—liver toxicity and masking of symptoms. She felt that over a twelve hour period, the patient could be monitored to see the course of symptoms and what steps needed to be taken next.

31. Dr. K-L testified that a fever of 106 is very high and that the patient should be checked by a doctor. She noted that R.R.'s incontinence was a sign that something was wrong that merited investigation. She noted that a high fever should be investigated whether or not the patient is taking other medications such as Clozapine. She made the same statements for the flu. Dr. K-L was questioned about R.R. refusing to go to the ER. She testified that she would have tried to strong-arm him into seeking treatment.

32. Dr. K-L was not notified by MVH staff the week of April 2, 2005 that R.R. had a fever, stool incontinence, or any other symptoms.

33. DAIL assigned N.T. to investigate the circumstances of R.R.'s death and MVH's compliance with licensing regulations. N.T. has been employed as a nurse surveyor at DAIL for nine years. She is certified by the Center for Medicare and Medicaid Services. She has been a R.N. since 1968.

34. N.T.'s duties include investigation of complaints or self-report investigations of long-term care facilities including residential care homes. N.T. conducts adult abuse investigations. She also conducts annual licensing surveys.

35. N.T. contacted petitioner to set up interviews on May 16, 2005. N.T. wanted to ensure that the petitioner and her staff were available for interviews. N.T.'s investigation focused on R.R.'s care; her investigation was not a full survey of MVH.

36. On May 16, 2005, N.T. went to MVH. She interviewed petitioner, T.S., S.J., and L.D. She reviewed R.R.'s progress notes and lab work. When N.T. first reviewed R.R.'s progress notes, she noticed that the progress notes from the time of death were missing. Petitioner provided those notes in a timely manner. In addition, she went to NEKHS and interviewed Dr. K-L and K.R., HIPAA compliance officer.

37. According to N.T., petitioner admitted that she did not notify L.D. or a doctor about R.R.'s fever spikes or stool incontinence. In addition, petitioner admitted that the staff had not explored other alternatives to the ER with R.R. Petitioner was not aware that the licensing regulations required her to contact the resident's physician when the resident refused treatment.

38. N.T. interviewed T.S. who described R.R.'s illness during the week of April 2 including fever, stool incontinence, and fatigue. T.S. thought R.R.'s symptoms might be the result of flu. T.S. reported that other MVH

residents had vomiting and diarrhea in March which T.S. characterized as the flu. N.T. learned when she interviewed L.D. that L.D. had not been informed by MVH staff that residents were sick in March. N.T. reviewed the files of four residents' who had been ill in March to check MVH's actions.

39. N.T. interviewed S.J. who stated that MVH had no policies and procedures regarding when staff should contact L.D. and had no policies and procedures for monitoring of side effects or behavioral changes of residents on psychotropic medications.

40. N.T. interviewed L.D. who explained that all of MVH residents were prescribed psychotropic medications. She admitted that there were no polices or procedures in place to monitor side effects or behavior changes of psychotropic medications. L.D. said she had been remiss in her duties due to personal issues.

41. N.T. reviewed R.R.'s records and found that R.R.'s dose of Clozapine was increased starting July 30, 2004 through January 24, 2005; but there were no nursing notes assessing the effect of the medication changes for a three and a half month period starting September 16, 2004. In

addition, there were no staff progress notes monitoring side effects or behavior changes.

42. N.T. reviewed the Physician's Standing Order and found that R.R. received Tylenol in excess of Dr. K-L's order.

43. N.T. interviewed Dr. K-L who indicated that she last saw R.R. on March 11, 2005. According to Dr. K-L, R.R. had blood work done every two weeks. The test results were within normal parameters. N.T. briefly reviewed the lab results.

44. Based on her investigation, N.T. issued a report on May 31, 2005, substantiating neglect by the petitioner because petitioner did not ensure that appropriate medical services were provided to R.R. N.T. noted that she did not consider R.R. capable of deciding what medical interventions were necessary based on his psychiatric diagnosis and treatment by large doses of psychotropic medications compounded by the impact of high fever spikes. N.T. testified that she did not believe that offering R.R. the ER was sufficient and that the petitioner and her staff should have explored other options with R.R.

45. Based on her investigation, N.T. found deficiencies or violations of the Residential Care Home Licensing Regulations. The particular violations include:

a. Regulation 5.8.a Physician Services requiring assistance to residents when needed to schedule medical appointments. N.T. based her decision on the failure of MVH staff to contact L.D. (MVH nurse) for an assessment or to help R.R. make a medical appointment.

b. Regulation 5.8.c. Physician Services requiring notification to resident's physician of refusal of medical treatment. N.T. based her decision on the failure of the petitioner to contact the resident's physician or to notify L.D. for an onsite assessment. N.T. added there were no policies for staff on when to notify the MVH nurse.

c. Regulation 5.9.c(7) Level of Care and Nursing Services including making contemporaneous records of illness including symptoms and action. When a resident has a change in his/her condition, the resident is to be reassessed by the nurse. N.T. based her decision on the fact that L.D. was not informed of the illness affecting residents in March and that L.D. was not informed of R.R.'s fever. Because L.D. was not informed, she was unable to reassess the residents.

d. Regulation 5.9.c.(12) includes the manager assuming responsibility for staff performance regarding resident medication. N.T. based her decision on the passage of a month between the medication incident report (Tylenol) and having L.D. conduct an evaluation and observation of a medication pass by the caretaker noted in the report.

e. Regulation 5.10.e. Medication Management including the type of training caretakers must receive before assisting residents with medications. N.T. based her decision on the lack of nursing oversight and the lack of any policies and procedures for

monitoring side effects and behavior changes related to psychotropic medications.

f. Regulation 4.13.b. Dealing with the manager's responsibility for daily management. N.T. based her decision on petitioner's failure to notify L.D. or a physician after becoming aware of a resident's high fever and stool incontinence.

46. Petitioner filed a plan of correction. According to Petitioner, she would correct all deficiencies by July 15, 2005. As part of her plan of correction, petitioner planned to take the following actions:

a. Care attendants will notify the petitioner and nurse of all changes in a resident's condition. The nurse would then assess the resident. The resident would be given options for medical intervention. If the resident refused medical intervention, the staff would note the refusal and the resident's physician would be notified. This action was modified by N.T. to include development of written policies and staff training.

b. Nurse will train staff regarding illness and body temperatures. This action was modified by N.T. to include training on signs of acute illness and to include development of written policies.

c. Meetings with NEKHS to improve communication.[3]

d. Staff will report changes of symptoms to nurse and petitioner and nurse will determine need for assessment and follow-up care. Incident reports will be completed. Nurse will review documentation on a weekly basis. This action was modified by N.T. to include petitioner oversight of compliance.

[3] Both petitioner and Dr. K-L testified that communication problems existed between MVH and NEKHS and that they were meeting to address issues.

e. Nurse will review medication administration and review records.

f. Nurse will provide training regarding medication administration including common side effects and will monitor staff performance.

g. Nurse will continue to use AIMs form (movement ratings) and other evaluation forms. Nurse will train staff regarding psychotropic medications including side effects, documentation of behavioral changes.

h. Petitioner will notify nurse of changes in a resident's condition.

47. N.T. and F.K., Licensing Chief for the Division of Licensing and Protection, made an unannounced visit to MVH on September 1, 2005 to check whether petitioner had complied with her plan of correction and rectified the deficiencies. As part of their investigation, they reviewed the files of five residents and interviewed staff and residents.

48. Based on her record review, N.T. found a number of deficiencies.

49. Resident Number One's records indicated that she was hospitalized at the beginning of June 2005 and subsequently admitted to a nursing home from June 7 until July 15, 2005. Prior to the her nursing home admission, the MVH care attendant characterized the resident as needing assistance with activities of daily living due to weakness. The care attendant reported that the resident's medications

were reduced at the nursing home leading to a major difference. Despite these changes, the resident had not been reassessed by L.D. There was only one nursing note during the period of January 1 through September 1, 2005 despite these changes. The resident was prescribed psychotropic medications. There was no formal monitoring of side effects or behavioral changes in relation to the psychotropic medication.

50. Resident Number Two had eloped three times between June 30 to July 10, 2005. The petitioner admitted there were no policies or procedures addressing elopement. In addition, the resident expressed suicidal ideation on July 8, 2005 and had requested illegal substances from another resident. These issues were not addressed in the care plan nor was a nursing assessment done by L.D. The resident was prescribed psychotropic medications but was not formally monitored for side effects or behavior changes.

51. Resident Number Three was hospitalized with a stroke in July 2005 leaving him with weakness on one side. The resident was not reassessed by L.D. and his care plan was not changed. He was prescribed psychotropic medications but he was not formally monitored for side effects or behavior changes.

52. Residents Number Four and Number Five were prescribed psychotropic medications but no formal monitoring was done for side effects or behavior changes.

53. N.T. documented deficiencies including:

a. Regulation 5.9.c(2) — lack of assessments and plans of care.

b. Regulation 5.10.e. — medication management.

c. Regulation 5.12.b(3) — not doing significant change assessments.

d. Regulation 5.15 — not having written policies and procedures (elopements).

e. Regulation 4.13.b. — manager's responsibility for daily management.

54. Both the May and September Statement of Deficiencies document problems with medication management including the formal monitoring of side effects and behavioral changes in residents receiving psychotropic medications (Regulation 5.10.e), the lack of nursing assessments when there is a change in the resident's condition (Regulation 5.9), and the lack of managerial oversight by petitioner of her staff (Regulation 4.13.b). Underlying these issues is a lack of written policies and procedures. The deficiencies noted under Regulation 5.8 in the May 16, 2005 survey are not noted in the September 1, 2005 survey.

55. DAIL called the petitioner as a witness.[4] Petitioner received a copy of the Residential Care Home Licensing Regulations when she opened MVH in 1994. Petitioner has attended trainings offered by DAIL including a manager's course during the 1990s. Petitioner is not a member of the Vermont Health Care Association, the trade organization for long-term care facilities.

56. Petitioner was questioned about her oversight of her staff, in particular L.D., and her written policies and procedures.

57. Petitioner was displeased with L.D.'s performance because L.D. was hard to contact. Despite her displeasure, petitioner continued to employ L.D. until November 2005. Petitioner agreed that she did not try to reach L.D. after she was notified about R.R.'s fever and episode of stool incontinence.

58. Petitioner was questioned about her oversight of L.D. Petitioner testified that she was technically L.D.'s boss but considered L.D. to be her supervisor in terms of medical issues.

[4] Subsequent to petitioner's testimony, the State indicated they planned to charge petitioner with criminal charges. Petitioner decided not to go forward with further testimony.

59. Petitioner was asked to describe policies she had in place to determine when a significant change occurred that would trigger a reassessment by the nurse. Petitioner disagreed with the September 1, 2005 survey that reassessments were not done. Petitioner stated they used a form titled "Illness/Concern Report" in answer to questions about policy. Petitioner was nonresponsive to questions about policy or procedures including what would trigger the need for a reassessment and the use of this form.

60. On October 4, 2006, Commissioner Flood wrote petitioner that he would not lift the ban on admissions.

61. On November 16, 2006, Commissioner Flood wrote petitioner that the November 3, 2006 follow-up inspection demonstrated that MVH was now in substantial compliance with the licensing regulations.

ORDER

DAIL's decision is affirmed.

REASONS

The Commissioner of DAIL is required by statute to investigate reports regarding the neglect of vulnerable adults. 33 V.S.A. § 6906. DAIL is required to keep reports that are substantiated in a registry under the name of the

person who committed the neglect. 33 V.S.A. § 6911(b). Persons who are found to have committed neglect may apply to the Human Services Board for relief on the grounds that the report in question is "unsubstantiated". 33 V.S.A. § 6906(d).

Neglect has been defined in 33 V.S.A. § 6902(7) as follows:

> "Neglect means purposeful or reckless failure or omission by a caregiver to:
>
> > (A)(i) provide care or arrange, and for goods or services necessary to maintain the health or safety of a vulnerable adult, including, but not limited to food, clothing, medicine, shelter, supervision, and medical services, unless the caregiver is acting pursuant to the wishes of the vulnerable adult or his or her representative, or a terminal care document, as defined in subchapter 2 of chapter 111 of Title 18.
> >
> > . . .
> >
> > (B) Neglect may be the repeated conduct or a single incident which has resulted in or could be expected to result in physical or psychological harm, as a result of subdivisions (A)(i). . .of this subdivision (7).

R.R. met the definition of a vulnerable adult who is to be protected from neglect. At the time in question, R.R. was a "person 18 years or older who: (A) [was] a resident of a facility required to be licensed under chapter 71 of this title". 33 V.S.A. § 6902(14)(A). Petitioner's residential

care home was a facility licensed under chapter 71. As the owner and manager of the facility, petitioner is a caregiver.

To better understand whether petitioner's actions constitute neglect, we need to look at petitioner's responsibilities as an operator of a Level III residential care home.

Residential care home is defined in 33 V.S.A. § 7102(1) as follows:

> (1) "Residential care home" means a place, however named, excluding a licensed foster home, which provides, for profit or otherwise, room, board and personal care to three or more residents unrelated to the home operator. Residential care homes shall be divided into two groups, depending upon the level of care they provide, as follows:
>
> (A) Level III, which provides personal care, defined as assistance with meals, dressing, movement, bathing, grooming, or other personal needs, or general supervision of physical or mental well-being, including nursing overview and medication management as defined by the licensing agency by rule, but not full-time nursing care;. . .
>
> In addition as a caregiver, petitioner's duties include providing medical care. 33 V.S.A. § 6902(2).

R.R. was a young adult with mental illness entrusted to the care of the petitioner because R.R. did not have the capacity to live independently. The expectation was that MVH would provide R.R.'s personal care needs including supervision of his physical well-being. Petitioner breached

her duty to R.R. through acts of omission by failing to provide those medical services necessary to maintain R.R.'s health.

To determine whether petitioner's omissions constitute neglect, we need to look at what petitioner knew about R.R.'s condition the week of April 2, 2005. By Wednesday evening (April 7), petitioner knew that R.R. had very elevated temperatures including a 106 reading during the previous weekend. On Thursday, petitioner was informed by a care attendant that R.R. spiked a 106 fever that morning. Petitioner was aware that R.R. had spiked extremely high temperatures over a several day period.

Although petitioner knew that R.R. had spiked extremely high temperatures over a short period of time, she did not treat this information as a significant change in his condition and did not call L.D., MVH nurse, to assess R.R.'s condition. Petitioner should have used L.D. as a resource to evaluate R.R.'s condition and the need for further medical intervention. In fact, L.D. did not learn about R.R.'s fevers and other symptoms until after his death.

Petitioner knew that the care attendant had asked R.R. to go to the ER and that R.R. refused to go to the ER. Petitioner treated the offer of the ER, in and of itself, as

a sufficient offer for medical treatment. Offering the ER is only one means of offering medical attention or services. Petitioner did not pursue other options for R.R. including (1) using L.D. to assess R.R., (2) calling his physician for advice, (3) asking his physician to make a home visit, and (4) contacting Dr. K-L at NEKHS.

Moreover, these options were not discussed or offered to R.R. Petitioner has argued that they had to honor R.R.'s wishes regarding treatment pursuant to Resident's Rights.[5] However, R.R. was never fully apprised of his options for medical treatment. R.R. refused the ER; R.R. did not refuse other medical treatment or intervention. Petitioner had options she could explore regarding R.R.'s medical needs; she did not explore these options.

On Friday, petitioner learned that R.R. had an episode of stool incontinence and was fatigued. R.R. had no history of stool incontinence. Because R.R.'s stool incontinence was so out of character, petitioner should have considered the stool incontinence a significant change in R.R.'s condition triggering the need for an assessment by L.D. Further, the

[5] Petitioner argues that honoring R.R.'s decision not to use the ER exempts her actions under 33 V.S.A. § 6901(A)(i). However, the statutory section is referring to decisions made by terminally ill patients to refuse life sustaining measures as referenced by the language regarding terminal care documents.

combination of spiked temperatures, fatigue, and stool incontinence should be considered a significant change in R.R.'s condition triggering the need for an assessment. Once again, R.R. was only offered the ER as an option. Once again, petitioner failed to follow through on R.R.'s medical needs by (1) not calling L.D. for an assessment, (2) not calling R.R.'s physician for advice, (3) not calling Dr. K-L at NEKHS, and (4) not exploring with R.R. his options for treatment.

Petitioner has argued that she did not know that R.R.'s fever might be life threatening because she did not know residents taking Clozapine were at risk when they ran fevers. Petitioner's argument is problematic for several reasons. First, both Dr. C and Dr. K-L testified that a 106 fever on its own is extremely serious and warrants medical attention whether or not a patient is taking Clozapine. Common sense dictates that extremely high fevers are a sign that medical attention is needed. Second, petitioner blamed Dr. K-L for not giving her information about Clozapine. However, Dr. K-L testified that several residents at MVH had been prescribed Clozapine prior to her work at NEKHS. MVH already had a familiarity with Clozapine prior to Dr. K-L prescribing the

drug to R.R.[6] Third, L.D. testified that she was aware of Clozapine's side effects and that MVH had written material on the drug.

The issue of neglect in this case focuses on petitioner's actions, not the actions of petitioner's staff or third parties. Petitioner argues that others are at fault or that she is being unfairly singled out. Petitioner's arguments do not address her accountability as the owner and manager of MVH or her individual responsibility in this case based on the information she had regarding R.R.'s health and the actions taken to address his health needs.

Petitioner raises an equal protection claim; however, there is no basis for an equal protection argument. Equal protection addresses disparate treatment of protected classes; classes based upon race, sex, religion, etc. See *Oyer v. Bove*, 368 U.S. 448 (1962) (challenging West Virginia's selective enforcement of its habitual criminal statute as violative of the equal protection clause of the 14th Amendment) stating at page 455:

[6] Pursuant to the statute, residential care homes are required to provide medication management. The licensing regulations address the need to monitor for side effects and behavior changes associated with psychotropic medication. Petitioner, as owner and manager, had an independent obligation to make sure that her staff had training, policies, and information necessary to perform these tasks.

> Moreover, the conscious exercise of some selectivity in enforcement is not in itself a federal constitutional violation. Even though the statistics in this case might imply a policy of selective enforcement, it was not stated that the selection was deliberately based upon an unjustifiable standard such as race, religion, or other arbitrary classification.

Further, as manager, petitioner's responsibilities included supervision of her staff, ensuring that staff received the training necessary to do their job, having policies in place that protect the residents, and taking steps to protect residents.

Petitioner had information demonstrating that R.R. was seriously ill. Petitioner had many opportunities to intervene by exploring options for R.R.'s medical care through consultation with L.D. or other medical professionals, by notifying L.D. and having L.D. assess R.R., and by offering R.R. options other than the ER. Petitioner's omissions rise to the level of neglect.

Petitioner also faces licensing violations. The operation of residential care homes are governed by 33 V.S.A. §§ 7101 *et seq*. Pursuant to 33 V.S.A. § 7101, the statutory purpose is:

> . . .to provide for the development, establishment and enforcement of standards for the construction, maintenance and operation of nursing homes and similar institutions in which medical, nursing or other remedial care is rendered, and of homes for the aged, which will

> promote safe surroundings, adequate care and humane treatment of such persons cared for in these facilities.

In furtherance of this provision, DAIL adopted Residential Care Home Licensing Regulations. These standards provide minimum standards of care. Petitioner is subject to these regulations.

Pursuant to 33 V.S.A. § 7111, DAIL has the following enforcement authority:

> (a) The licensing agency shall enforce provisions of this chapter to protect residents of facilities.
>
> (b) The licensing agency may require a facility to take corrective action to eliminate a violation of a rule or provision of this chapter within a specified period of time. If the licensing agency does require corrective action:
>
> (1) the licensing agency may, within the limits of resources available to it, provide technical assistance to the facility to enable it to comply with the provisions of this chapter;
>
> (2) the facility shall provide the licensing agency with proof of correction of the violation within the time specified; and
>
> (3) if the facility has not corrected the violation by the time specified, the licensing agency may take such further action as it deems appropriate under this section.
>
> (c) The licensing agency may impose an administrative penalty against a facility for failure to correct a violation or failure to comply with a plan of corrective action for such a violation, as follows:

> (1) up to $5.00 per resident or $50.00, whichever is greater, for each day a violation remains uncorrected if the rule or provision violated was adopted primarily for the administrative purposes of the licensing agency;
>
> (2) up to $8.00 per resident or $80.00, whichever is greater, for each day a violation remains uncorrected if the rule or provision violated was adopted primarily to protect the welfare or the rights of residents;
>
> (3) up to $10.00 per resident or $100.00, whichever is greater, for each day a violation remains uncorrected if the rule or provision violated was adopted primarily to protect the health or safety of residents;
>
> (4) for purposes of imposing administrative penalties under this subsection, a violation shall be deemed to have first occurred as of the date of the notice of violation…

Our authority is to determine whether the evidence supports DAIL's findings of licensing violations. If violations occurred, the Board cannot substitute its judgment for the Department's judgment as to remedy. *Huntington v. Dept. of Social and Rehabilitation Services*, 139 Vt. 416 (1981).

The initial investigation was triggered by R.R.'s death. The scope of that investigation was limited to the circumstances of R.R.'s care. The initial investigation resulted in the May 16, 2005 notice of deficiencies.

Petitioner submitted a Plan of Correction to address the deficiencies.

DAIL performed a follow-up survey on September 1, 2005. DAIL found that petitioner had not corrected all the deficiencies. DAIL did not note continuing violations of regulation 5.8. In addition, they found additional deficiencies upon their review of a random sample of five resident files.

R.R.'s death raised significant concerns about medication management including the lack of specific policies for monitoring side effects and behavioral changes in residents receiving psychotropic medications, training of staff, and sufficient oversight by the nurse.

Regulation 5.10 governs medication management. Pursuant to 5.10a, residential care homes must have written policies describing their practices. Subsection 5.10e sets out the training requirements for staff assisting residents with medication.

When the nurse surveyor returned on September 1, 2005, she reviewed five resident files. All five residents were prescribed psychotropic medications. She found they had not been formally monitored for side effects or behavior changes. In addition, the nurse was not providing oversight.

The investigation into R.R.'s death targeted the deficiencies in the level of care and nursing services. Regulation 5.9 sets out the requirements for nurses to complete assessments including assessments when there are changes in the resident's condition, develop written plans of care, make sure that signs or symptoms of illness are recorded at time of occurrence as well as actions taken, and ensure that changes in a resident's condition are recorded. In R.R.s case, the nurse was not notified about the changes in his condition. As a result, the nurse was unable to do a reassessment or ensure that proper records were kept.

When the nurse surveyor returned, she found there were still deficiencies regarding regulation 5.9. In particular, two residents had significant health changes. One resident was hospitalized with a subsequent nursing home stay; the caretakers indicated there had been changes in the resident's abilities and condition. The other resident had a stroke resulting in weakness on one side. But, the nurse had not assessed these residents. A third resident expressed suicidal ideation, but no nursing assessment was done. That same resident eloped three times from the facility. The petitioner did not have a policy for elopements.

The nurse surveyor found continuing deficiencies under regulation 4.13b which deals with the manager's responsibility for daily management of the residential care home. When the nurse surveyor returned, she found that the petitioner was not assuring that the nurse was providing proper oversight regarding medication oversight and change assessments. Petitioner argues that she does have a policy by pointing to a particular form she developed to document illness or concern. However, petitioner could not answer questions regarding what policy informed the use of the form. A form is a tool to implement a policy. Petitioner's testimony was not forthcoming about her policies and practices.

The evidence demonstrates that the petitioner not only violated licensing requirements but continued to do so after filing her Plan of Correction. Petitioner argues that the regulations are vague and that she has been unable to obtain information or help from DAIL. The regulations were properly adopted. They are minimum standards that residential care homes have followed for years.

In conclusion, DAIL's decision to substantiate neglect and to find licensing violations is affirmed. 3 V.S.A. § 3091(d), Fair Hearing Rule No. 17.

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